## Claimant's Statement

**U.S. Department of Labor**
Employment Standards Administration
Office of Workers' Compensation Programs
www.dol.gov/esa/owcp/dlhwc/index.htm

Loss of compensation benefits may result if this report is not completed and filed in accordance with instructions (33 U.S.C 944) | OMB No. 1215-0160

1. _____ Place within brackets_____

Name and Address of Beneficiary (Type or Print)

2. OWCP No.

3. Carrier's No.

4. If you are receiving death benefits as a surviving spouse, please state whether you have remarried.
☐ Yes ☐ No If "Yes", give name of spouse and date of marriage.

5. If payments are being made on behalf of a beneficiary as a student, is the beneficiary still enrolled in school as a full-time student?
☐ Yes ☐ No

6. Name and Address of school beneficiary is attending.

I hereby acknowledge receipt of compensation from the U.S. Department of Labor, Division of Longshore and Harbor Workers' Compensation, and certify that the above information is true and correct.

(*Signature*) (Telephone No.) (Name of Signer) (*Date*)

Important Notice: Section 31(a)(1) of the Longshore Act, 33 U.S.C. 931 (a)(1), provides as follows: Any claimant or representative of a claimant who knowingly and willfully makes a false statement or representation for the purpose of obtaining a benefit or payment under this Act shall be guilty of a felony, and on conviction thereof shall be punished by a fine not to exceed $10,000, by imprisonment not to exceed five years, or by both.

**Form LS-267**
**Rev. Jan.2009**

**PRIVACY ACT OF 1974 NOTICE**

In accordance with the Privacy Act of 1974, as amended, (5 U.S.C. 522a), you are hereby notified that:
(1) The Longshore and Harbor Workers' Compensation Act (LHWCA), as amended and extended (33 U.S.C. 901 et seq.) LHWCA is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor which receives and maintains information on claimants and their immediate families.
(2) Information which the Office has will be used to determine eligibility for the amount of benefits under the LHWCA.
(3) Information may be given to the employer which employed the claimant at the time of injury, or to the insurance carrier or other entity which secured the employer's compensation liability.
(4) Information may be given to the physicians and other medical service providers for use in providing treatment or medical/vocational rehabilitation, making evaluations and for other purposes relating to the medical management of the claim.
(5) Information may be given to the Department of Labor's Office of Administrative Law Judges (OALJ), or other person, board or organization, which is authorized or required to render decisions with respect to the claim or other matter arising in connection with the claim.
(6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the LHWCA, to determine whether benefits are being and have been paid properly, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by law.
(7) Failure to disclose all requested information may delay the processing of the claim, the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Note: The notice applies to all forms requesting information that you might receive from the Office in connection with the processing and/or adjudication of the claim you filed under the LHWCA and related statutes.

**Public Burden Statement**

The following statement is made in accordance with the Privacy Act of 1974 (5USC 552a) and the Paperwork Reduction Act of 1995, as amended. The authority for requesting the following information is 20 CFR 702.285. Use of this form is optional, however furnishing the information is required in order to obtain and/or retain benefits. According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 1215-0160. The time required to complete this information collection is estimated to average 2 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any aspect of this collection of information, including suggestions for the reducing this burden, to the U.S. Department of Labor, Division of Longshore and Harbor Workers' Compensation, Room C-4315, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

**Do not send the completed form to this office.**

This form is used to collect information relating to the payment of death benefits. The information provided will be used to determine entitlement to death benefits.